Washington State Department of Social & Health Services
DBHR Division of Behavioral Health and Recovery

State of Washington
Department of Social and Health Services
Division of Behavioral Health and Recovery

OPIATE TREATMENT PROGRAM APPLICATION ADDENDUM

Applicant: Use this form as an addendum to a DBHR application for certification as a new opiate treatment program, for a branch location, or for adding a service to an existing certified chemical dependency service program, and to identify the required federally recognized opiate treatment program (OTP) accreditation body.

Please complete **PARTS I. through VII.** of the application addendum form, return the form with the completed information, and the required materials with your new provider, branch, or added service application to the DBHR address listed at the end of this application addendum.

I. PRE APPLICATION REQUIRMENT

An OTP Community Relations Plan is required to be submitted to and approved by DBHR prior to submission of an OTP application. This form is located at: http://www.dshs.wa.gov/dbhr/daforms.shtml#dbhr in Opiate Treatment Application Forms.

☐ The OTP Community Relations Plan has been submitted and approved.

II. AGENCY INFORMATION

Name of Agency/OTP:

Address of OTP:

III. APPLICATION TYPE

Check one:
This addendum was included with an application for:

☐ **Certification as a New Chemical Dependency Service Provider.**

If applying for certification as a new Washington State chemical dependency service provider, ensure the policy and procedure manuals submitted with your application meets the requirements of 42 Code Federal Regulations (CFR) Part 8.12,- Certification of Opioid Treatment Programs.

☐ **Certification of a New Branch of an existing Certified Chemical Dependency Service Provider.**

☐ **Certification of an Added Service of an existing Certified Chemical Dependency Service Provider.**
If applying for certification to provide opiate substitution treatment at a currently certified Washington State chemical dependency service facility, ensure the policy and procedures manuals submitted with your application meets the requirements of 42 CFR Part 8.12, - Certification of Opioid Treatment Programs.

IV. CITY, COUNTY OR TRIBAL INFORMATION

Washington Administrative Code (WAC) 388-805-035(1) requires DBHR to consult with the city, county or tribal legislative authorities in which an applicant proposes to locate as an OTP. Therefore, please provide the following information:

I have determined the proposed location of the OTP:

☐ Is not within the area of any Tribal Trust Land or Reservation, or,
☐ Is within the area of the following Tribal Trust land or Reservation.

Tribal Trust Land or Reservation:	
Tribal Chair:	
Mailing Address:	
Telephone:	**Fax:**
E-mail Address:	

I have determined the proposed location of the OTP:

☐ Is not within the incorporated area of any city; or,
☐ Is within the incorporated area of the following city:

City:	
City Legislative Authority:	
Mailing Address:	
Telephone:	**Fax:**
E-mail Address:	

I have determined the proposed location of the OTP:

☐ Is not within the county; or,
☐ Is within the following county:

County:	
County Legislative Authority:	
Mailing Address:	
Telephone:	**Fax:**
E-mail Address:	

V. FEDERALLY APPROVED ACCREDITATION BODY SELECTION

If a new OTP, you are required to select a federally recognized accreditation body. Check one of the below OTP Substance Abuse and Mental Health Services Administration (SAMHSA) approved accreditation bodies.

We choose to be accredited as an OTP by:

☐ The Joint Commission

☐ The Commission on the Accreditation of Rehabilitation Facilities (CARF).

☐ Council on Accreditation (COA).

☐ Washington State Division of Behavioral Health and Recovery (DBHR).

If you selected DBHR as your accreditation body, this application addendum will serve as your application for accreditation as an OTP. There are no additional fees required for DBHR accreditation.

If you change your mind about your choice of accreditation body prior to the award of accreditation, please notify DBHR within seven days of your decision.

VI. ADDITIONAL MATERIALS TO BE SUBMITTED WITH YOUR APPLICATION

A. As required by WAC 388-805-030, attach copies of your:

1. Application for a registration certificate from the Washington State Board of Pharmacy. http://www.doh.wa.gov/hsqa/professions/pharmacy/forms.htm

2. Application for licensure to the Federal Drug Enforcement Administration. http://www.deadiversion.usdoj.gov/drugreg/reg_apps/onlineforms_new.htm

3. Application for certification to the Center for Substance Abuse Treatment (CSAT), SAMHSA. http://dpt2.samhsa.gov/sma162/

If **not** selecting DBHR as the federally recognized accreditation body, then attach a copy of your:

4. Application for accreditation by an accreditation body approved by CSAT, SAMHSA. http://www.dpt.samhsa.gov/regulations/accredbodies.aspx

B. Documentation that transportation systems will provide reasonable opportunities to persons in need of treatment to access the services of the program as required by WAC 388-805-030(8).

C. When operating an OTP in another state, a copy of the national accreditation, state certification/accreditation, and survey reports from national or state certification or accreditation organizations over the past six years as required by WAC 388-805-030(11).

D. At least three letters of support from other providers within the existing health care system in the area of the proposed OTP program location to demonstrate an appropriate relationship to the service area existing health care system as required by WAC 388-805-030(9).

VII. DECLARATIONS

OTP SPONSOR

I agree on behalf of the program to adhere to all requirements set forth in WAC 388-805, RCW 70.96A, 42 CFR Part 8.12 and the CSAT Guidelines for the Accreditation of Opioid Treatment Programs.

I also agree to limit the number of individual program participants to 350 as specified in RCW 70.96A.410(1)(e) and required by WAC 388-805-030(10).

Signature of the OTP Sponsor:	**Date:**
Type or Print Name:	**Title:**
Address:	**Telephone:** **( )**
E-mail Address:	

OTP MEDICAL DIRECTOR

I assume the responsibility for administering all medical services performed by the OTP. Additionally, I recognize my responsibility for ensuring that the OTP complies with all applicable Federal, State, and local laws and regulations.

Signature of the OTP Medical Director:	**Date:**
Type or Print Name:	**Title:**
Washington State Licensed Physician Number and Expiration Date: **Number:**	**EXPIRES:** / /
Address:	**Telephone:** **( )**
E-mail Address:	

Return this original OTP Addendum to:

Division of Behavioral Health and Recovery
Department of Social and Health Services
Certification Section
Post Office Box 45330
Olympia, Washington 98504-5330

If you need technical assistance regarding the OTP Addendum, or need a copy of any regulations cited in this application form, please contact the DBHR Certification Provider Request Manager at: (360) 725-3819; or FAX: (360) 586-0343 or E-mail: darrel.streets@dshs.wa.gov

In most cases, DBHR will review and respond to your request within 30 days from the date of receipt of all the required information.